Appendix 3

Completed Sample HCFA 1500 Claim Form - Second Pregnancy

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PATIENT'S NAME (Last N		idale initial)			TIENT'S BIF		SEX F 🟋	4. INSURED'S	NAME (L	ast Nam	ie, First i	vame, r	vilaaie i	nitiat)		
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TY	·		STATE	8. PA	TIENT STAT	TUS		CITY		***************************************				5	STATE	
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OTHER INSURED'S POLICE	CY OR GROUP NU	MBER		a. EN	1PLOYMENT	T? (CURRENT	OR PREVIOUS)	a. INSURED'S	DATE OF	BIRTH	l			SEX		
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OTHER INSURED'S DATE	_	SEX		b. AU	ITO ACCIDE	NT? YES	PLACE (State)	b. EMPLOYER	'S NAME	OR SCI	HOOL N	AME				
M F F					HER ACCID	a INCLUDATION	- DLANC	ANAE C	2 0000	D 444 5.	A B 4 F					
EWIFLOTER 5 NAME OR	GUNUUL NAME			0.01		YES	NO	c. INSURANCE	- FLAN N	AIVIE OF	- FRUGI	nawi N	NIVIE			
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. RESERVED FOR LOCAL USE					d. IS THERE ANOTHER HEALTH BENEFIT PLAN?							
								YES NO If yes, return to and complete item 9 a-d.								
RE . PATIENT'S OR AUTHOR	EAD BACK OF FOR	M BEFORE	COMPLETIN	NG & SIG	NING THIS	FORM.	ormation necessary	13. INSURED'S			ED PERS	SON'S	SIGNA	TURE I at	thorize	
to process this claim. I als	so request payment of	f governmen	t benefits eith	er to mys	elf or to the p	party who acce	pts assignment	payment of services de				idersign	ieu priy	SICIAITOI	варрнег ю	
below.																
SIGNED	▲ ILLNESS (Firet ov	motom) OP	16	E PAT	DATE_	IAD SAME OF	SIMILAR ILLNESS	SIGNED	TIENTII	MARIE"	TO WOR	K IN C	IBBEN	IT OCCU	PATION	
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)					IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY				FROM ! TO !							
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 17a. I.D. NUMBER OF REFERRING PHYSICIAN								18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY								
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. RESERVED FOR LOCAL	USE							20. OUTSIDE L				\$ CHAF	RGES	ı		
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21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS - 1.1 V 23.9					11410112	22. MEDICAID RESUBMISSION ORIGINAL REF. NO.										
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(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500